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Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, *et al.*,

Petitioners,

—v.—

WILLIAM E. SIMON,
Secretary of the Treasury, *et al.*,

Respondents.

IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

BRIEF *AMICUS CURIAE* OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

SYLVIA A. LAW
40 Washington Square South
New York, New York 10012
Attorney for the American Public Health Association

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BRIEF *AMICUS CURIAE* OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

Interest of the American Public Health Association

This Brief is presented in support of the Petition for Writ of Certiorari filed on behalf of Eastern Kentucky Welfare Rights Organization, *et al.* Counsel for both the petitioners and respondents have consented to the filing of the instant Brief *amicus curiae*.

The American Public Health Association is a national non-governmental organization established in 1872. Its object is to protect and promote personal and environmental health. With a membership of over 50,000, it is the largest public health organization in the world. Within

this membership, both professional health workers and consumers act in a leadership role to develop a national health policy to provide equitable, low-cost, quality health care for all citizens. At its annual convention in 1970, the APHA took note of the fact that many non-profit hospitals in the United States had failed to live up to their legal obligations to make free and below cost care available to persons unable to pay.

The APHA believes that through Revenue Ruling 69-545 the Internal Revenue Service destroyed rights of vital importance to the health of millions of Americans. We are deeply disturbed that the IRS effectuated this major change in federal policy apparently on the basis of erroneous assumptions of fact and without affording health professionals or the public an opportunity to provide information and comment.

Summary of Argument

For over thirty years the non-profit hospitals of America have received massive government subsidy, both direct and indirect, on the basis of representations and legal requirements that they provide charitable services to people unable to pay. The Internal Revenue Service, in Revenue Ruling 69-545, abolishes the requirement that hospitals enjoying tax exempt status must provide free care to those unable to pay. This change in the tax treatment of non-profit hospitals was specifically rejected by the Congress.

Over one-fifth of the American population has no hospital insurance. In recent years the net income of non-profit hospitals has increased at a rapid pace while the

public hospital sector has found it increasingly difficult to provide necessary services to the growing numbers of people who are unable to pay for hospital services.

The IRS decision to abolish the requirement that tax exempt hospitals must provide free care to those unable to pay is based on factual assumptions about the delivery of health care in America. Even though the IRS has no particular expertise in this area, they proceeded without providing the public or the health professions any opportunity to provide information or comment.

ARGUMENTS

I. Revenue Ruling 69-545 impermissibly effects a major change in established federal policy in relation to both the provision of hospital services and charitable tax exemption.

One of the most important devices which Congress uses to encourage activities which it believes will be useful to the Nation is to grant exemption from the taxes which would otherwise be collected, and to allow deductions for private contributions to designated activities. In Section 501(c)(3) of the Internal Revenue Code, Congress provided in broad terms that non-profit organizations which provide charity are tax exempt.[1] The courts below found that the intended beneficiaries of the charitable services upon which this exemption is based have sufficient interest in the receipt of those services to allow them standing to challenge the action of the Internal Revenue

[1] Int. Rev. Code of 1954, 26 U.S.C. §501(c)(3). The statute is set forth in the Petition for Writ of Certiorari, p. 64a.

Service in abolishing rights which would otherwise be theirs. The APHA supports this decision.

Section 501(c)(3) also grants tax exemption to certain classes of activities which Congress has deemed inherently useful, whether or not they are provided on a charitable basis. (For example, education, scientific study for public safety, prevention of cruelty to children or animals.) The Petitioner's Application for a Writ of Certiorari raises two questions of fundamental importance. First, whether the Internal Revenue Service has the power to eliminate the requirement that tax exempt hospitals provide "charity" and thereby expand the class of non-profit activities which shall be considered *per se* worthy of tax exempt status under 501(c)(3), or whether that power rests with the Congress. And second, whether the Administrative Procedure Act requires that in eliminating the right to expect charitable services from non-profit tax-exempt hospitals, the Internal Revenue Service should obtain information and comment from the public and professionals who have some particular knowledge and interest in health care delivery.

Revenue Ruling 69-545 effects a major change in long standing federal tax exemption policy, which is not authorized by the statute and which, indeed, was explicitly rejected by the Congress.[2] To qualify for exemption under the plain language of the Code, a hospital must be both non-profit *and* charitable. The class of people dependent upon non-profit tax exempt hospitals to provide them with needed hospital care was large when the action was filed. Unfortunately it is now growing astronomically. Despite

[2] See opinion of the district court below, Petition for Writ of Certiorari, pp. 552a-56a.

the growth of private insurance and the enactment of Medicaid and Medicare, the Social Security Administration estimates that in 1972, one-fifth of the population under the age of 65 had no financial shield against the hazards of illness. Still larger numbers had only minimal insurance protection.[3] 38 million Americans under age 65 had no hospital insurance and 43 million had no insurance for medical care costs.[4]

Since February 1972 the official unemployment rate has risen from 5.8% to 8.2%.[5] The 8.2% rate of unemployment represents more than 7.5 million workers.[6] High unemployment has a direct and drastic impact on the number of persons who have no insurance or other third party coverage for hospital costs. The recent Staff Report of the House Committee on Interstate and Foreign Commerce notes that although a variety of bills have been introduced in Congress to provide federal funds to pay health insurance premiums for unemployment compensation recipients who had health insurance at their previous place of employment, even if these bills are enacted, large numbers of unemployed persons would still be without hospital coverage. Under the bills, two large classes are excluded. First, many of the unemployed are not eligible for unemployment compensation for a variety of reasons; this group is estimated to number at least 1.5 million out of the 7.5

[3] M. S. Mueller, "Private Health Insurance in 1972: Health Care Services, Enrollment, and Finances," Social Security Bulletin, March 1974 at 21.

[4] *Id.* at 20.

[5] Bureau of Labor Statistics, as cited in Staff of House Comm. on Interstate and Foreign Commerce, 94 Cong. 1st Sess., "Health Insurance and the Unemployed," March 10, 1975, at 11. Also Bulletin Almanac, 1974, at 194.

[6] *Id.* at 12-20.

million unemployed.[7] The second group of ineligibles are those unemployed persons who are drawing unemployment benefits, but did not have health insurance coverage at their previous place of employment. Most employers have a waiting period before workers are eligible to participate in group health programs. Since the last hired are often the first fired, "it is easy to see that the probability exists for many to be laid off before gaining eligibility to the health plan."[8]

The previously well established rights of this growing class of people are at stake in this case. For almost three decades it has been the firm federal policy of this country to encourage and assist the development of the non-profit voluntary hospital, which would be available to serve all members of the community. In 1946 Congress enacted the Hospital Survey and Construction Act, to create, through the voluntary sector, "a state-wide system of hospitals for the provision of hospital services to all the people of the state."[9] Over 470,000 hospital beds were constructed with these federal funds between 1947 and 1971. Over 280,611, or 59.7% of these federally financed beds are located in private, non-profit community hospitals.[10] Over the years the American Hospital Association has solicited funds from both the government and the American people on the premise that hospital services would be available to people who need them, without regard to ability to pay. For example, in 1969, Mark Burke, then President Elect of

[7] *Id.* at 3 and 20.

[8] *Id.* at 33.

[9] *Simkins* v. *Moses H. Cone Mem. Hosp.*, 323 F.2d 959, 968 (4th Cir. 1963) (*en banc*), *cert. denied*, 376 U.S. 938 (1964).

[10] DHEW, Public Health Services, "Hill-Burton Project Register, July 1, 1947-June 30, 1971," Doc. No. 72-4011, p. 21.

the American Hospital Association, told the House Committee on Ways and Means:

> "The institutional health care system differs from the rest of the private sector in its philosophy toward and treatment of patients who are unable or unwilling to pay. Other members of the private sector maintain their right not to sell their product to someone who cannot afford it . . . Community hospitals, because of their public responsibility do not take such action. The right to receive such service regardless of the ability to pay is extended to the entire community."[11]

Revenue Ruling 69-545 flies in the face of the clear federal policy encouraging the development of non-profit charitable hospitals to serve the community, particularly that portion of the community which is unable to pay for hospital services either directly or through insurance.

Revenue Ruling 69-545 does not require non-profit hospitals to provide charity in any accepted sense of the word. It requires hospitals to accept patients whose health insurance is financed through the Medicaid and Medicare programs. Despite the statement of the American Hospital Association to the contrary,[12] Medicaid and Medicare pay hospitals the full reasonable costs of the services provided to individuals who are insured under these programs.[13]

[11] Hearings on Social Security and Welfare Proposals before the House Comm. on Ways and Means, 91st Cong. 1st Sess., Pt. 4, at 1069 (1969).

[12] Brief *Amicus Curiae* of the American Hospital Association, at n. 3.

[13] See *Catholic Medical Center* v. *Rockefeller*, 305 F. Supp. 1256 (E.D.N.Y. 1969), vacated and remanded, 397 U.S. 820 (1970), order reentered, 305 F. Supp. 1268 (E.D.N.Y. 1970), aff'd *per*

Hence this requirement is nothing more than a statement that exempt hospitals may not arbitrarily discriminate against certain classes of people who are able to pay the full cost of the service. Sound policy reasons support a rule that tax exempt hospitals should not arbitrarily discriminate against particular groups of people who are fully able to pay, whether that discrimination is based on race, age or economic class. However, prohibiting arbitrary discrimination against particular classes of paying patients, does not meet the statutory requirement that a non-profit hospital must provide charity in order to be tax exempt.

Similarly, the requirement that a non-profit hospital have an emergency room does not require that the hospital provide charity. Certainly emergency room service is an important component of any general hospital. Over 37% of the non-profit hospitals in this country do not have "basic emergency services."[14] But the mere existence of an emergency room does not assure that charitable services will be provided. The widespread policy of many non-

curiam, 430 F.2d 1297 (2d Cir. 1970), appeal dismissed, 400 U.S. 931 (1970).

See also 39 Fed. Reg. 31766 (1974), in which the Secretary of HEW notes that the federal Medicaid law requires full payment of all reasonable costs and states: "Concern has been expressed by representatives of the American Hospital Association that some States have in the past, in violation of their Title XIX State plans, failed to reimburse hospitals at the required reasonable cost level . . . The Secretary knows of no instance, however, in which such a violation has occurred without being promptly rectified with full reasonable cost reimbursement of all services provided by hospitals. If there should in the future be any instance in which States fail to adhere to State plan requirements, affected hospitals are urged to so inform the appropriate Regional Commissioner of the Social and Rehabilitation Service."

[14] Journal of the American Hospital Association, Guide Issue, 484 (Aug. 1971).

profit hospitals is to "dump" on to the public hospitals any patients who lack money or insurance and who require hospitalization and other services.[15] Revenue Ruling 69-545 requires only that a tax exempt hospital have an emergency room. The hospitals are entirely free to transfer all uninsured patients to the public hospital, if that is the hospital's choice. Revenue Ruling 69-545 does not assure that any charitable care will be provided by the non-profit organization enjoying the benefit of tax exemption.

In 1969 the Internal Revenue Service sought Congressional authorization for the specific policy embodied in Revenue Ruling 69-545. Congress refused to provide that authorization. To free the non-profit tax exempt hospitals from the long standing obligation to provide charitable care to those unable to pay obviously represents a fundamental change in federal policy with respect to both hospital services and tax exemption. Congress was not willing to make that change.[16] Respondents have exceeded their legal authority in thus amending the tax law. The fundamental importance of the rights at stake warrant the review of this Honorable Court.

[15] See Roemer & Mera, "Patient Dumping and Other Voluntary Agency Contributions to Public Agency Problems," 11 Med. Care 30 (Jan.-Feb. 1973). Woodward, "Poor Hurt by Transfers, Doctor Says," Washington Post, Sept. 30, 1971, at 17, col. 1.

[16] See discussion in the Opinion of the District Court below, Petition for Writ of Certiorari, pp. 55a-56a.

II. Revenue Ruling 69-545, and the decision of the court below are based on erroneous assumptions about health care delivery.

This Court should grant certiorari to assure that fundamental changes in federal policy are adopted in accordance with the requirements of the Administrative Procedure Act providing interested parties an opportunity to place the essential information before the governing agency.

The opinion of the Circuit Court upholding Revenue Ruling 69-545 as a permissible exercise of IRS discretion is based on "factual assumptions which are not supported by a record and which plaintiffs have not had an opportunity to rebut." [17] We respectfully submit that the factual assumptions of the Circuit Court are, quite simply, wrong. The Circuit Court assumed that, "the institution of Medicare and Medicaid in the last decade combined with the rapid growth of medical and hospital insurance has greatly reduced the number of poor people requiring free or below cost hospital services." [18] We have already shown that this assumption is tragically inaccurate. The Circuit Court also seems to assume that because of rising hospital costs and reduced philanthropic contributions the private non-profit hospitals are not able to provide a significant amount of free and below cost care. The third assumption is that local government is increasingly able to provide non-emergency hospital care for those unable to pay.

[17] Opinion of Bazelon, C.J. dissenting from denial of Motion for rehearing *en banc*, set forth in Petition for Writ of Certiorari, at p. 3a.

[18] The opinion is set forth in the Petition for Writ of Certiorari. See pp. 24a-25a.

Despite a decrease in the amount of philanthropic contributions, non-profit hospitals in America have never been in better financial shape. The most recent Social Security Administration study of the subject shows that during the period 1961-71, the net income as a rate of return on plant assets in non-profit hospitals rose from 1.4% to 3.0%.[19] Stated another way, in non-governmental community hospitals total revenue rose from $5.0 billion in 1961 to $18 billion in 1971, while expenses increased at a lesser rate, from $4.9 billion to $17.6. This HEW study summarizes, "overall *net* income grew tremendously, from $110 million in 1961 to $547 million in 1971." [20]

What does a non-profit hospital do when it has a substantial excess of income over expenses, as has been the case in recent years? It could increase the amount of free and below cost care which it provides to people unable to pay. Or, as has more often been the case in American hospitals, it could build a new wing. In 1974, conservative estimates, both governmental and private, placed the number of excess, unnecessary acute care hospital beds in America at between 67,000 and 110,000.[21] In 1974, 4.5

[19] J. Pettengill, "The Financial Position of Private Community Hospitals, 1961-71," Social Security Bulletin, Nov. 1973, at 10.

[20] *Id.* at p. 3.

[21] In 1972 the federal Hill-Burton agency estimated that there were 110,000 excess acute care hospital beds in the United States. DHEW Health Resources Administration, Health Care Facilities Services, "General Hospitals and Outpatient Facilities, Existing and Needed as of Jan. 1, 1971" (1972). The 67,000 estimate of excess beds is based on a private study assuming that an optimal nation-wide occupancy rate is 81%. Sattler & Bennett, "A Statistical Profile of Short Term Hospitals in the U.S. as of 1972," Interstudy, Minneapolis, Minn. (1974). These reports are summarized at 120 Cong. Rec. 22259 (Daily Ed. Dec. 19, 1974).

billion dollars was spent for the construction of yet more new hospital beds.[22] Since it costs an average of $20,000 a year to maintain the standby, operational costs of each empty hospital bed, we paid about $2 billion in 1974, through public and private insurance programs, to maintain unneeded, unused hospital beds.[23] Stated another way, in 1974, $60 was added to the cost of each hospital stay in the United States simply to finance the maintenance of empty, unnecessary hospital beds.[24]

As serious as this waste of money is, even more tragic is the resulting loss of human life. It has long been recognized that where a substantial proportion of the population have pre-paid hospital insurance, there is a definite tendency to fill the hospital beds. This tendency, known in the health delivery field, as Roemer's Law, was first formally observed by Milton I. Roemer, a long standing active member of the American Public Health Association.[25] Other more recent studies have shown a close correlation between the number of hospital beds and the amount of

[22] Remarks of Eugene Rubell, Director Bureau of Health Planning Service and Resources Development, HEW, "Excess Hospital Construction Blocked," N.Y. Times, Dec. 16, 1974, at 14, col. 4.

[23] Regional Health Planning Council, North Central Texas Council of Governments, "The Financial Impact of Hospital Overbedding," June 1974. See also Lave and Lave, "Hospital Cost Functions," LX Am. Econ. Rev. 3 (1970).

[24] C. B. Ensminger, "The Eight Billion Dollar Hospital Bed Overrun," Health Research Group, Wash., D.C., 1975, at 1.

[25] M. Shaine and M. I. Roemer, "Hospital Costs Relate to the Supply of Beds," 92 Mod. Hosp. 71 (April 1959); M. I. Roemer, "Bed Supply and Hospital Utilization: A Natural Experiment," 35 Hospitals 36 (Nov. 1, 1961).

elective surgery.[26] A recent study by the General Accounting Office estimated that 25% of the hospital beds in America are filled with people who do not need to be there.[27] Approximately three million unnecessary elective surgical procedures were performed in the United States in 1973.[28] Given the risks inherent whenever an individual undergoes general anesthesia for surgery, it is apparent that a large number of lives are unnecessarily lost each year as a result of unnecessary elective surgery. We might all be better off, both financially and physically, if non-profit hospitals devoted a greater proportion of their excess resources to providing necessary services to people who are unable to pay, and less to the construction of further unnecessary inpatient facilities.

The third operative assumption of the court below is that "increasingly counties and other political subdivisions are providing non-emergency hospitalization and medical care for those unable to pay."[29] The contribution of local government to the cost of health care has increased dramatically in recent years, both through the pro-

[26] See Dr. C. Lewis, "Variations in the Incidence of Surgery," 281 N. Eng. J. of Med. 889 (1969).

[27] General Accounting Office, "Study of Health Facility Construction Cost," Report to the Congress by the Comptroller General, 1972, at 759.

[28] Various studies estimate that 20% of elective surgery performed in this country is unnecessary. McCarthy, "Effects of Screening by Consultants on Recommended Surgical Procedures," 291 N. Eng. J. of Med. 1331 (1974). Dr. L. Williams, ***How to Avoid Unnecessary Surgery***, Nash Pub. 1971. See also, MacLeod & Prussin, "The Continuing Evolution of Health Maintenance Organizations," 288 N. Eng. J. of Med. 439 (1973). In 1973 there were 15.4 million elective surgical procedures performed under general anesthesia. American Hospital Association, ***Hospital Statistics, 1974***, at 34.

[29] Petition for Writ of Certiorari, p. 24a.

vision of service in public hospitals and through local financial contribution to the cost of care provided in private hospitals.[30] However, it is also well known that local governments in many areas face serious financial problems which make it difficult to expect them to take up the provision of charity hospital care which has historically been the responsibility of the non-profit, tax exempt hospitals.

The American Public Health Association believes that Revenue Ruling 69-545 represents a drastic change in the previous law, eliminates important rights of the citizens whom Petitioners represent, has a substantial impact upon both the public and private sectors of the hospital industry, and is necessarily predicated upon assumptions of fact which are not within the particular expertise of the Respondent. Under settled principles, all of these reasons require that the Respondent comply with the rule making procedures of the Administrative Procedure Act.[31] If the Respondent had complied with the procedures mandated by the Administrative Procedure Act, and had received a full range of relevant information, we believe that the policy change effectuated by Ruling 69-545 might never have been made.

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[30] Between 1966 and 1973 the percentage of national health care expenditures financed through public funds increased from 25.7% to 39.9%. B. Cooper, *et al.*, "National Health Expenditures, 1929-73," Social Security Bulletin, March 1974, p. 4. During the same period the aggregate contribution to health care services from state and local sources increased from $4,542 million in 1966 to $10,230 million in 1973. *Id.* at p. 15. *Memorial Hospital* v. *Maricopa County*, 415 U.S. 250 (1974) may cause further increases in state and local contribution to health care services for short term residents.

[31] See *Citizens to Preserve Overton Park* v. *Volpe*, 401 U.S. 402 (1971). See also *Lewis-Mota* v. *Secretary of Labor*, 469 F.2d 478 (2d Cir. 1972); *Texaco* v. *Federal Power Comm'n*, 412 F.2d 740 (3d Cir. 1969).

CONCLUSION

For the foregoing reasons, it is respectfully submitted that the Petition for Writ of Certiorari should be granted.

Respectfully submitted,

SYLVIA A. LAW
40 Washington Square South
New York, New York 10012
Attorney for the American Public Health Association